Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pine Creek Medical Center

Respondent Name
ATK Launch Systems Inc

MFDR Tracking Number
M4-10-3663-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 16, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The disputed fee should be paid in accordance with TDI-DWC §134.404. Hospital Facility Fee Guideline Inpatient. Carrier failed to notify HCP of any contractual agreement therefore, we request that this claim be paid in accordance with TDI-DWC Medical Fee Guidelines."

Amount in Dispute: $40,954.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per our records total paid $95,304.70 will provide check info under separate cover."

Response Submitted by: The Hartford, 300 S. State St. Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 16 - 18, 2009	Inpatient Hospital Surgical Services	$40,954.30	$40,954.30

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §133.4 sets out requirements regarding written notification to health care providers of contractual agreements for informal and voluntary networks.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - 5 – The procedure code/bill type is inconsistent with the place of service
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - W3 – Additional payment made on appeal/reconsideration
   - B12 – Services not documented in patients medical records

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §133.4 states in pertinent part, "(a) Applicability. This section applies to health care services that are rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider in accordance with Labor Code §413.011 and §413.0115. (b) Person. Under this section "person" is defined as an individual, partnership, corporation, hospital district, insurance carrier, organization, business trust, estate trust, association, limited liability company, limited liability partnership or other entity to whom an informal network or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed on behalf of an insurance carrier. This term does not include an injured employee. (c) Required Notice. Each informal network or voluntary network, or the insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall notify each affected health care provider of any person that is given access to the informal or voluntary network's fee arrangement with that health care provider within the time and manner provided by this section. (d) Notice. Notice to each contracted health care provider: (1) must include the contact information for the informal or voluntary network, including, but not limited to, the name, physical address, and a toll-free telephone number accessible to all contracted health care providers; (2) must include the following information in the body of the notice: (A) name, physical address, and telephone number of any person that is given access to the informal or voluntary network's fee arrangement with a health care provider; and (B) the start date and any end date during which any person has been given access to the health care provider's contracted fee arrangement. (3) may be provided in an electronic format provided a paper version is available upon request by the Texas Department of Insurance, Division of Workers' Compensation (Division); and (4) may be provided through a website link only if the website: (A) contains the information stated in paragraphs (1), (2)(A) and (2)(B) of this subsection; and (B) is updated at least monthly with current and correct information.

   The insurance carrier reduced or denied disputed services with reason code "45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 29, 2010, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the healthcare provider had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required.

   - The notice does not include the start date and any end date during which the insurance carrier had been given access to the contracted fee arrangement as required by §133.4(d)(2)(B).

The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.404 (f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

3. 28 Texas Administrative Code §134.404§134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Review of the documentation found supports that the following items were certified as required by (g):

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
278	IMP DePuy NDL Jamshidi	None submitted	n/a	n/a	Not supported with invoice
278	IMP ISOTIS BONE CHIPS 15CC	$265.00	1 @ $265.00	$265.00	$291.50
278	IMP ISOTIS BONE CHIPS 15CC	None submitted	n/a	n/a	Not supported with invoice
278	IMP MEDSTAR DBM 10CC	Origen DBM 10cc	1 @ $3,250.00	$3,250.00	$3,575.00
278	IMP OMNI ROD 5.5 X 40MM	5.5mm x 40m Pre-Bent Rod	2 @ $495.00	$990.00	$1,089.00
278	IMP ISOTIS PUTTY 100 DBM AVO3	EV03 10cc	1 @ $1,900.00	$1,900.00	$2,090.00
278	IMP OSTEO GRAFTON PUTTY 5CC	5cc Grafton DBM Putty	1 @$800.00	$800.00	$880.00
278	IMP OMNI SCR 6.0 X 45MM	6 x 45mm Reduction Screw	4 @ $1,495.00	$5,980.00	$6.578.00
278	IMP SP-SMITH BONE FUSIONARY	Fusionary 60ml	1 @ $1,995.00	$1,995.00	$2,194.50
278	IMP NV-SP MODULE II MONTRNG	Per Manufacturer's description "disposable". Does not meet the definition of implantable	n/a	n/a	n/a
278	IMP NV-SP STIMULATN CLIP LG	Per Manufacturer's description "disposable". Does not meet the definition of implantable	n/a	n/a	n/a
278	IMP OMNI SPACR 14 MM	ALIF Cage 14mm 7	1 @ $7,500.00	$7,500.00	$8,250.00
278	IMP OMNI SET SCR CAP	Set Screw Caps	4 @ $400.00	$1,600.00	$1,760.00

$24,280.00	$26,280.00
Total Supported Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

4. 28 Texas Administrative Code §134.404 (f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

   - Documentation found supports that the DRG assigned to the services in dispute is 454, and that the services were provided at Pine Creek Medical Center. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $46,061.42. This amount multiplied by 108% results in an allowable of $49,746.33.
   - The total cost for implantables is $24,280.00. The sum of the per-billed-item add-ons exceeds the $2000 allowed by rule; for that reason, the total allowable amount for implantables is $24.280.00 plus $2,000, which equals $26,280.00.

   Therefore, the total allowable reimbursement for the services in dispute is $49,746.33 plus $26,280.00 which equals $76,026.33. The respondent issued payment in the amount of $28,400.00. The requestor is seeking $40,954.30, this amount is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $40,954.30 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 16, 2014 Date
Signature	Medical Fee Dispute Resolution Manager	October 16, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.